South Carolina Department of Disabilities and Special Needs

Authorization for PDD Waiver Case Management Services

TO: _____

_____

RE: _____

Recipient's Name / **Date of Birth**

_____

Address

Medicaid # /_____/_____/_____/_____/_____/_____/_____/_____/_____/_____/_____/

_____

Parent Name / **Phone Number**

You are hereby authorized to provide the following service(s) to the recipient named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorizations to this provider for this service(s).

Case Management Services:

Number of units per year: _____

Start Date: _____

Service Coordinator/Early Interventionist: Name / Address / Phone Number / E-mail **(Please Print)**

_____

_____

_____

_____

Signature of person authorizing services **Date**